closed claim study

Failure to diagnose retained surgical retractor

by Barbara Rose and Laura Brockway

The following closed claim study is based on an actual malpractice claim from Texas Medical Liability Trust. This case illustrates how action or inaction on the part of physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physicians' defensibility. The ultimate goal in presenting this case is to help physicians practice safe medicine. An attempt has been made to make the material less easy to identify. If you recognize your own claim, please be assured it is presented solely to emphasize the issues of the case.

Presentation and physician action

A 29-year-old man with a long-standing history of abdominal complaints was referred to general surgeon A for evaluation of a duodenal ulcer. After examination and evaluation, general surgeon A diagnosed a chronic peptic ulcer and recommended vagotomy and subtotal gastric resection.

The surgery commenced. A sponge count was completed at the end of the surgery, but an instrument count was not conducted and no instrument count was printed on the OR form. In the following weeks, the patient seemed to do well. He last saw general surgeon A eight weeks after the surgery.

Approximately 18 months later, the patient came to his family physician with complaints of severe lower stomach pain for three or four months. This physician noted the patient had undergone a partial gastrectomy 18 months prior. Over the next year, the physician provided conservative treatment. When this failed to alleviate his abdominal symptoms, the patient was referred to a radiologist for an air contrast barium enema.

Radiologist A reported that the films showed "a very large unusual radiopaque structure in the anterior abdomen. It appears very thin and flat and extends virtually the length of the abdomen. It is located anteriorly and may be superficial in the anterior abdominal wall, although its exact location and etiology is not known. It may be related to the patient's midline incision, aside from this the patient's abdomen appears unremarkable on the scout film."

Two weeks later, the patient saw a gastroenterologist on referral from his family physician. The gastroenterologist did not have the patient's records or radiographic studies available at the time of the examination. He believed the patient suffered from chronic abdominal pain syndrome, but he planned to locate the patient's records and evaluate them. The records were relayed to the gastroenterologist, including the barium enema study that noted the radiopaque material in the abdomen. The gastroenterologist concluded this material was an unusual form of surgical mesh related to the patient's surgical procedure. He believed that the patient was suffering from prostatitis and felt there was not a GI source for the symptoms. No further GI work up was needed.

Three days after his final visit to the gastroenterologist, the patient came to the emergency department of hospital A. He complained of lower scrotum and abdominal pain, and was seen by ED physician A. An abdominal x-ray was ordered and was read by radiologist B. He concluded "there is an anteriorly located 'mesh' in the subcutaneous tissue most likely related to an abdominal anterior wall hernia correction. There are several surgical clips in the left upper quadrant and surgical staple line to the right of the mesh at the L2 level. There are dense probably residual contrast collections either in the appendix or Secale region in the lower right quadrant. The bony structures are unremarkable. There are minimal degenerative changes." Radiologist B believed there were surgical changes in the abdomen with no evidence of acute abdominal process. ED physician A diagnosed acute prostatitis, and advised the patient to continue taking the medication prescribed by the gastroenterologist.

Over the next year, the patient continued under the care of the family physician. The medical records indicate the patient continued complaining of abdominal pain.

Three years and 10 months after the surgery, the patient came to the ED at hospital B. ED physician B's impression was that the patient suffered from acute abdominal pain, left ureterolithiasis, and hematuria with a high grade left renal ureter obstruction. ED physician B noted in his chart that there was an intra-abdominal metallic foreign body. A urologist examined the patient and reviewed the IVP with radiologist C. They both noted a small distal left ureteral stone and a metallic density on the film, which they believed to be mesh related to the patient's prior surgery. The urologist discharged the patient, as he was pain free.

The patient returned to the ED five days later and was seen by the same urologist. He felt the patient was suffering from a left ureteral stone and ordered the patient's admission. The next morning, the patient was pain free. The urologist encouraged him to increase the pain medication, to strain his urine and attempt to pass the stone. The patient was discharged and told to return to the urologist in one week. The patient did not return to the urologist. However, after receiving a notice of claim regarding this patient, the urologist made two additional entries into the patient's chart indicating the patient failed to keep appointments.

Two years after the visit to hospital B, (now five years and nine months after the surgery) the patient came to the ED at hospital C complaining of abdminal pain. An x-ray was reported as unremarkable, but the patient reported that he was known to have a wire mesh in his abdomen. The impression by ED physician C was acute abdominal pain. The patient was seen again in the ED of hospital C nine days later. The x-ray report noted metallic clips in the upper portion of the abdomen due to the prior surgery which two wide plates superimposed over the right paravertebral region, possibly representing a back brace. The x-ray was again reported as a negative x-ray of the abdomen.

Following these two visits to hospital C, the patient came to general surgeon B who ordered a CT scan and reviewed the previous abdominal x-rays. General surgeon B diagnosed a retained metallic foreign body,

probably a surgical ribbon retractor, as the cause of the patient's pain. The patient was taken to surgery, and the surgeon found and removed a 3-inch-wide x 13-inch-long surgical ribbon retractor.

The patient's records indicate that he had not undergone any other abdominal procedures other than the vagotomy and subtotal gastric resection. It appeared that the retractor was left at the time of this surgery.

The patient testified that since the removal of the retractor he has experienced no other abdominal complaints.

Allegations

A lawsuit was filed against general surgeon A and the hospital where the surgery took place, alleging negligence in leaving a ribbon retractor in his abdomen during the surgery. The patient also filed suit against all the physicians who treated him after the surgery, alleging negligence in failure to diagnose the retained retractor. Named in the suit were the family physician, the gastroenterologist, the urologist, the three ED physicians, and the three radiologists. This incident was featured in a news story on medical mishaps and aired on a network investigative news program.

Legal implications

The plaintiffs in this case effectively developed their case to pursue two claims: the act of leaving the retractor and the subsequent failure to diagnose it. The surgeon who removed the retained retractor provided a report critical of all those involved in the first surgery.

Defense radiology experts were critical of radiologist B for describing the metal as "mesh,"and that this description led to a delay in diagnosis and removal of the foreign object. This report should have triggered further work-up by the referring physician. The consultants also concluded that radiologist A's report fully described the retractor, and that the referring physician should have followed up on that report.

Other defense consultants were not entirely supportive of the actions of the urologist and the gastroenterologist. The main weakness in the case against the gastroenterologist was the failure to follow up on the cause of the patient's abdominal pain and the radiology report submitted by radiologist A. Regarding the actions of the urologist, he was under the impression that the prior physicians and the patient were aware of the foreign object based on the previous radiology studies. However, other urology experts were critical of his apparent inability to recognize the retained object as a surgical retractor. The urologist's alteration of the medical record also undermined his defense.

As is often the case when claims involve multiple defendants, finger pointing became an issue. The plaintiff's attorney was able to develop conflicting testimony and criticisms between the various subsequent physicians. This, coupled with the damaging testimony from the plaintiff's own experts, significantly hindered the defense of this case.

Disposition

Given the "shock value" of this case and the difficulty in obtaining supportive defense testimony, this case was settled with the consent of the physicians. Settlement was made on behalf of general surgeon A, the gastroenterologist, the urologist, and radiologist B. The case against radiologist A was dropped. The hospital where the surgery took place also settled this case. The outcome of those suits against the other defendants is unknown.

Risk management considerations

There could not be a more compelling example to justify instrument counts in the operating room. The summary of this claim tells the story. It is difficult to comprehend that it took almost six years, visits to multiple hospitals and physicians who ordered many tests to accurately identify the etiology of the plaintiff's complaints.

An action requiring comment is that of the defendant urologist who, after notice of claim, made two entries in the medical record regarding appointments that were not kept by the plaintiff. Physicians and their practices are encouraged to implement a "no show" system that is used in a timely manner. Document in the record that the patient did not keep their appointment. Contact the patient and document this action in the record.

A late entry or addendum in a medical record is to be clearly identified with the current date of documentation and the date referenced for the added information. Once a physician has received a notice of claim, it is inadvisable to add any notes to the medical record.

Barbara Rose can be reached at barbara-rose@tmlt.org. Laura Brockway can be reached at laura-brockway@tmlt.org.

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legislative update . . . *continued from page 3*

Senate Bill 465 — administration of psychoactive medication
Expands the application requirements for a physician to request a court order to permit the administration of psychoactive medications to a patient refusing the medication.

House Bill 984 — students with diabetes
For every student with diabetes in Texas public elementary and secondary schools, a personal diabetes management and treatment plan must be developed by the student's parent/guardian and physician.

Medicaid
Restored podiatry, eyeglasses, and hearing aid benefits for adults.

CHIP (Children's Health Insurance Plan)
Restored dental, vision, hospice, and mental health benefits. Established perinatal benefits.

- A physician (not just ob-gyns) who provides Medicaid services to a pregnant woman shall inform the woman of the CHIP benefits for which she or the woman's child may be eligible.

Texas Medical Board (formerly the Texas State Board of Medical Examiners)

The 2005 Texas legislature made wide-ranging changes to the laws related to physician's practices. The Board is now working (with stakeholder input) to adopt rules in accordance to those changes.

- Reduced fees and CME requirements for retired physicians who provide only charity care. Liability insurance shall also be made available to charity physicians. Retired physicians providing care through a disaster relief organization are exempt from the registration fee.
- Prescription delegation to a registered nurse or physician assistant need not be registered with the TMB. However, records must be maintained by the physician.
- Requirements for TMB mental or physical examinations were expanded to include applicants, not just licensees. Examination can be required only in cases involving mental/ physical health conditions, substance abuse or professional behavior problems.
- TMB must publish its disciplinary action errors and reversals in the same manner it published the original action.
- Removed the statutory exemption from Office-based Anesthesia rules for physicians who use only moderate sedation. Physicians must now follow the TMB's Office–based Anesthesia rule when administering anxiolytics and analgesics even if there is no probability of placing the patient at risk for loss of life-preserving protective reflexes. The Office-based Anesthesia rule requires:
- annual registration and compliance with detailed standards; or
- certification or licensure of the facility.